

CHURCHILL COUNTY SCHOOL DISTRICT
Special Services Department

EVALUATION/REEVALUATION REPORT

STUDENT NAME: _____ DOB: _____ DATE: _____
 SCHOOL: _____ GRADE: _____ STUDENT #: _____
 PARENT NAME: _____ DATE TRIENNIAL DUE: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 PHONE NUMBER: _____ PREVIOUS ELIGIBILITY CATEGORY (IF APPLICABLE): _____

DATA GATHERING SUMMARY

The following items have been reviewed by the members of the student's Eligibility Team and IEP Committee. This review will assist the team in determining continued eligibility, programming and placement. Copies of items referred to herein are filed in the student's Confidential Folder.

_____ Progress Reports	_____ Evaluations and Information	_____ Current Classroom Performance
_____ Discipline File	_____ Provided by the Parents	_____ Curriculum Based Assessment
_____ Structured Student Interview	_____ Confidential File	_____ Health/Development History
_____ Group Test Scores	_____ Classroom Observation	_____ Medical/Psychological Records
_____ Work Samples	_____ Transcripts	_____ Other Assessments _____
_____ Previous Evaluation Findings	_____ Cumulative Student Record	
	_____ Guidance Records	

ADDITIONAL EVALUATION AND/OR DATA NEEDS

The following areas were reviewed with the parent/guardian, the IEP Committee and the Eligibility Team regarding additional evaluation and/or data collection needs. Check and describe areas requiring additional evaluation and/or data collection

<input type="checkbox"/>	No Additional Assessments are Needed	
<input type="checkbox"/>	Additional Assessments are Needed	
	ADDITIONAL ASSESSMENTS NEEDED:	ASSESSMENT INSTRUMENTS:
<input type="checkbox"/>	Cognitive Abilities	
<input type="checkbox"/>	Adaptive Skills/Self Help Skills	
<input type="checkbox"/>	Social or Emotional Condition; Behavior	
<input type="checkbox"/>	Academic Achievement	
<input type="checkbox"/>	Speech Language	
<input type="checkbox"/>	Sensory- Fine Motor	
<input type="checkbox"/>	Gross Motor	
<input type="checkbox"/>	Health/Development/Medical	
<input type="checkbox"/>	Learning Process	
<input type="checkbox"/>	Assistive Technology	
<input type="checkbox"/>	Other	

SUMMARY

1. _____ If additional data is required, send Parent Prior Written Notice and obtain signed Parent Consent for reevaluation requiring additional data.
2. _____ If no additional data is required, send Parent Prior Written Notice (indicating that no additional assessment information is needed)

Distribution: White – Confidential File Yellow – Parent/Student Pink- Special Services

March 2007

TELEPHONE INTERVIEW INFORMATION

Date of Phone Interview:	Interviewed by:
Person Interviewed:	Relationship to Student:
INTERVIEW INFORMATION:	

ELIGIBILITY TEAM AND IEP COMMITTEE MEMBERS	
POSITION	NAME OR SIGNATURE
LEA REPRESENTATIVE	
SPECIAL EDUCATION TEACHER	
REGULAR EDUCATION TEACHER	
PARENT/GUARDIAN	
STUDENT (at age 14)	
SCHOOL PSYCHOLOGIST	
SPEECH/LANGUAGE SPECIALIST	
OCCUPATIONAL THERAPIST	
PHYSICAL THERAPIST	
SCHOOL NURSE	
OTHER (TITLE)	
OTHER (TITLE)	
OTHER (TITLE)	